IHS TRIBAL CONSULTATION
CHS Listening Session

MARCH 7, 2012
PALA, CA

Contract Health Services

- CHS Defined
- CHS Claims Processing
- IHS Medical Priorities
- CHS Funding History and CHEF
- Government Accountability Office Investigation
- Annual Request for CHS Deferral and Denial Data

Can CHS pay for your referral medical care?
This is a decision tree that describes 3 stages.

Individual Qualifications

Stage 1
You are eligible if:

a) You are a member or descendent of a Federally recognized Tribe or have close ties acknowledged by the CHSDA Tribe*

and

b) You live on the reservation or, if you live outside the reservation, you live in a county of the CHSDA

Each Contract Health Service Delivery Area (CHSDA) covers a single Tribe or a few Tribes local to the area. You are ineligible for CHS elsewhere.*

and

c) You get prior approval for each case of needed medical service or give notice within 72 hours in emergency cases (30 days for elders & disabled)

No for the above

Application is denied.

* *There are a few narrowly defined exceptions. Ask CHS staff for more specifics about individual eligibility, CHSDA, or prior notice.*

Yes for all

Relative Medical Priorities

Stage 2
Payment may be approved if:

a) The health care service that you need is medically necessary

– as indicated by medical documentation provided

and

b) The service is not available at an accessible IHS or Tribal facility

and

c) The facility's CHS committee determines that your case is within the current medical priorities of the facility

*Unfortunately, CHS funds often are not sufficient to pay for all needed services. When this happens, the committee considers each individual's medical condition to rank cases in relative medical priority. Cases with imminent threats to life, limb, or senses are ranked highest in priority. ***

d) CHS funds available are sufficient to pay for the service to be authorized

No for the above

Application is deferred.

** *Ask CHS staff for more specifics. Sometimes deferred lower priority cases may be reconsidered later if funding permits.*

Yes for all

Coordination and Payment

Stage 3
Approval, Billing, Payment

a) You must apply for any alternate resources for which you may be eligible *– Medicare, Medicaid, insurance, etc.*

then

b) A CHS purchase order is issued to a provider authorizing payment for services

then

c) IHS or Tribal staff and the authorized provider coordinate your medical care

then

d) The authorized provider bills and collects from your alternate resources

then

e) The authorized provider bills any unpaid balance to CHS for payment
– because CHS is payer of last resort, it pays only for costs not paid by your alternate resources

Steps are completed in order

Provider is paid.

Specific services authorized within relative medical priorities may vary from time-to-time in response to changing supply and demand, especially to stretch diminished funds over the remainder of the fiscal year.

California
Contract Health Service Delivery Area (CHSDA)
25 USC Sec. 1680

- The State of California, excluding the counties of Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Francisco, San Mateo, Santa Clara, Kern, Merced, Monterey, Napa, San Benito, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Stanislaus, and Ventura **shall be designated as a contract health service delivery area (CHSDA) by the IHS for the purpose of providing contract health services to Indians in such State**

- Originally defined on September 30, 1976, P.L. 94-437
- IHCIA, permanently authorized March 23, 2010

IHS Medical Priorities

- Because CHS level of funding is only a fraction of the need, an equitable and rational system is needed to prioritize the severity of injury and/or illness
- Tribal healthcare programs that elect to follow IHS regulation on medical priorities may use Indian Health Manual Exhibit 2-3-D as a guideline
- Deviations from IHS regulations should demonstrate fairness and equity, and be medically necessary

Level I

- Emergent or acutely urgent healthcare services
- Necessary to prevent death, or serious impairment
- Examples:
  - Bone fractures
  - Acute pneumonia
  - Obstetrical deliveries and post-natal care
  - Acute psychiatric care of suicidal person
  - Acute cardiopulmonary problems
  - Acute renal failure
  - Bowel obstruction

Level II

- Preventive healthcare services
- Aimed at preventing disease, or disease complications
- Many GPRA measures fit under Level II
- Examples:
  - Routine prenatal care
  - Immunizations
  - Screening exams, such as mammography, colonoscopies
  - Vision and hearing
  - Diagnostic procedures (X-ray, lab) supporting primary care

Level III

- Primary and secondary healthcare services
- For conditions that would lead to progressive loss of function if not treated
- Non-acute diagnoses
- Examples:
  - Many specialty consultations in ophthalmology, ENT, dermatology, orthopedics, psychiatry, non-acute cardiology, pain medicine
  - Routine, elective surgeries such as gall bladder surgery, hernia repair, some back surgeries
  - Eyeglass refraction, hearing aids, orthotics

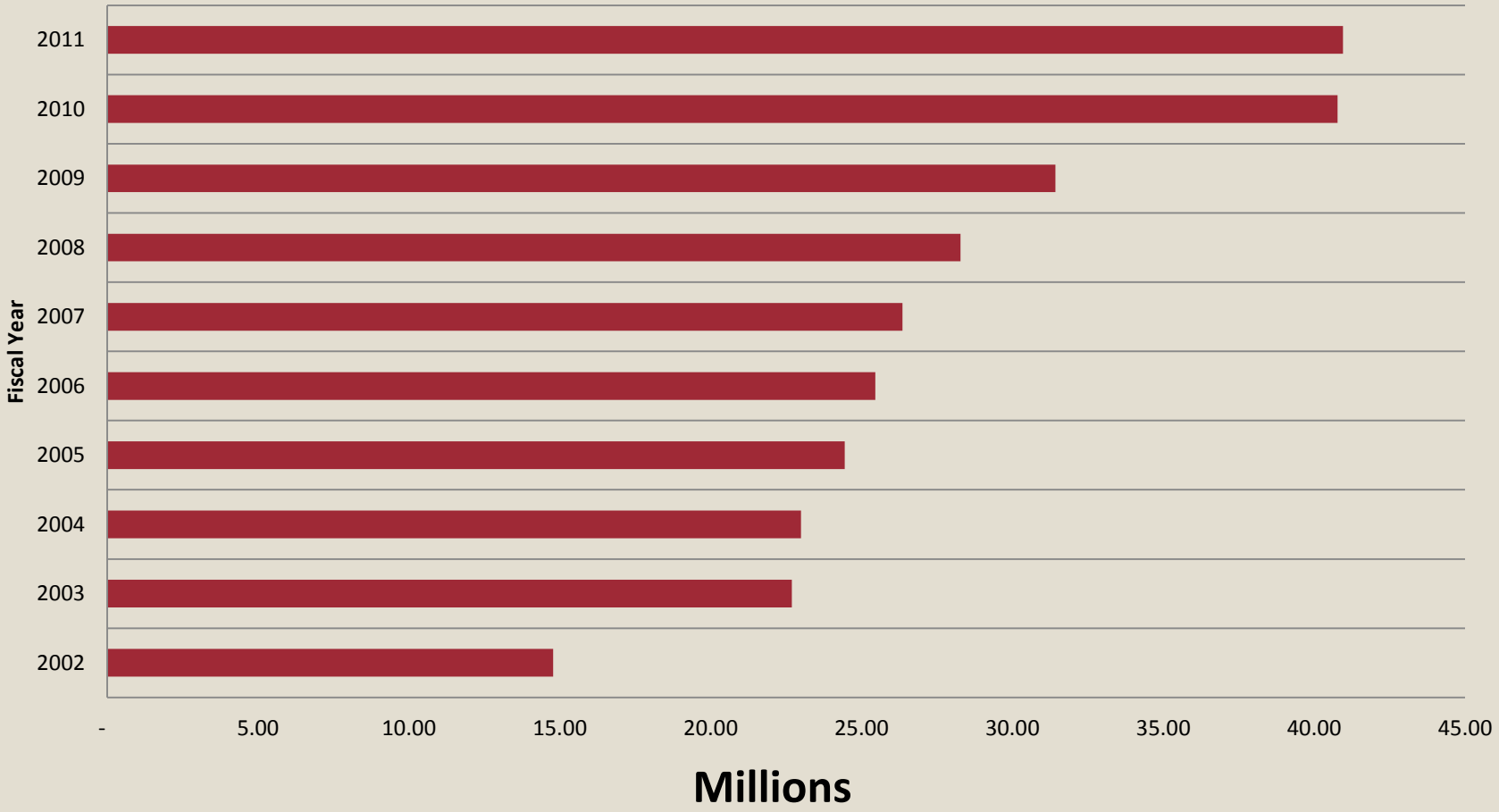
Level IV

- Chronic tertiary and extended healthcare services
- Not essential
- Low impact on morbidity and mortality
- High cost
- Examples:
  - Obesity surgery
  - Joint replacement
  - Reconstructive surgery
  - Non-acute coronary bypass surgery
  - Pain medicine procedures

Level V

- Excluded services
- Generally cosmetic, experimental/investigational clinical trials
- Examples:
  - Tattoo
  - Tattoo removal
  - Dermabrasion
  - Breast augmentation
  - Face lift
  - Custodial care
  - "Tummy tuck"
  - Experimental drugs or devices not approved by the U.S. Food and Drug Administration

California CHS Funding



Catastrophic Health Emergency Fund

- Initially established in 1987 “solely for the purpose of meeting the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illness who are within the responsibility of IHS”
- Threshold is $25,000 per episode of care
- Some California Tribal healthcare programs have difficulty meeting the threshold and underutilize this benefit

Catastrophic Health Emergency Fund

California Distributions		
Year	**# Cases**	**Amount**
2006	14	660,585
2007	4	157,549
2008	3	45,721
2009	12	280,304
2010	8	179,671
2011	11	736,362

Government Accountability Office (GAO) Investigation of Contract Health Services

Purpose

The GAO examined:

(1) The extent to which IHS ensures the data it collects on unfunded services are accurate to determine a reliable estimate of CHS needs.

(2) The extent to which federal and tribal CHS Programs report having funds available to pay for contract health services, and

(3) The experiences of external providers in obtaining payment from CHS program

GAO Surveyed 66 Federal and 177 Tribal CHS Programs and spoke to IHS Officials and 23 providers

GAO Findings

- Not all CHS Programs are reporting unmet needs
  - 5 of the 66 federal and 30 of the 103 tribal CHS programs responded they did not submit data to IHS in FY 2009
- Inconsistencies found
  - There is a National workgroup established in 2010 to examine weaknesses in its current data and explore other sources of data to estimate need
  - The corrective action plan incorporates the workgroup recommendations into the GAO findings

GAO Recommendations

1. Ensure that area offices submit data on unfunded services from all federal CHS programs
2. Conduct outreach and technical assistance to tribal CHS programs to encourage and support efforts to voluntarily provide data that can be used to better estimate the needs of tribal CHS program
3. Develop an annual data reporting template that requires area offices to report available deferral and denial counts for each federal and tribal CHS program

GAO Recommendations

4. Develop a plan and timeline for improving the agency's deferral and denial data

5. Develop ways to enhance CHS program communication with private sector providers, such as providing regular trainings

Deferred Healthcare Services

- Budget guidelines for recording and reporting:
  - Patient accesses the health care system during reporting period
  - Reporting period is (October 1 thru September 30) based on federal fiscal year and must be tracked and submitted to IHS/CAO by December of each year
  - Healthcare service is not emergent or urgent
  - Required healthcare service is not accessible or available in local direct healthcare system
  - Healthcare service/treatment deferred must be within the IHS medical priorities

Deferred Services

Preventative Healthcare Services:

- Audiology evaluations & hearing aids (V53.2)
- Allergy Testing, injections, Etc.
- Antenatal screening (V28.1)
- Dental hygiene (teeth cleaning)
- Family planning services: vasectomies & tubal ligations
- Mammograms
- Podiatry care For diabetics
- Physical therapy
- Pap Smear (Routine)
- Refractions, glasses, contact lenses
- Sexually transmitted disease Services
- Other

Deferred Services

Acute & Chronic Healthcare Services:

- Cardiac procedures
- Dental procedures
- Ears, Nose & Throat Procedures
- Gynecological Procedures
- Medical Referral/Procedures
- Ophthalmologic Services
- Orthopedic Procedures
- Prosthetic/Orthotics
- Psychiatric Evaluations
- Surgical Referral Procedures

Deferred Services

Tertiary Healthcare Services:

- Coronary bypass and valvular surgery
- Transplants
- Neurosurgery
- Restorative surgery; cleft palate, skin grafts
- Pacemaker implants
- Lithotripsy
- Other acute chronic tertiary care

CHS Denials

- Reason for denials
  - No prior authorization for non-emergency services
  - Not within tribal health programs medical priorities
  - Not CHS eligible
    - Non-beneficiary
    - Does not reside within the CHSDA
  - No 72 hour notification for emergencies
  - Up to 30 day notification for disabled & elderly
  - Lack of available funds

Contract Health Services

- California Denial data for 2010 and 2011:

California Area	(A) Eligible But Care Not Within Medical Priority	(B) Eligible But Alternate Resource Available	(C) Patient Ineligible for CHS	(D) Emergency Notification Not Within 72 Hours	(E) Non-Emergency Prior Approval Not Authorized	(F) Patient Resides Outside CHSDA	(G) IHS Facility Available And Accessible	(H) All Other Denials	(I) TOTAL (A-H)
2010 TOTAL (24 sites)	1,101	1859	689	465	645	169	128	1517	6,573
2011 TOTAL (24 sites)	9,267	24,635	7,318	15,668	974	1,452	18	428	59,760

Contract Health Services

FY 2012 Projected California Shortfall

Total Estimated CHS Need	Number of Cases Reported in FY2011	Calculated Number of Cases for FY2012	Projected Shortfall Dollar Amount for FY2012 (Millions)
Denied	9,267	26,106	$114,719,307
Deferred	758	2,134	$ 25,847,375
TOTAL	10,025	28,240	$140,566,682

Summary

- Collecting and reporting accurate CHS deferral and denial data drives the CHS unmet need analysis for IHS budget increases in its annual CHS appropriation
- Recent interest and scrutiny of the CHS budget line item by external authorities is commensurate to the recent increases to the CHS budget
- Based on FY2011 deferral and denial data, the IHS/CAO projects a FY2012 CHS shortfall of $140, 566, 682. This projection exceeds all previous measures of unmet need.